2009 Benefit Summary Matrix for Conversion Product

Aetna Health of California Inc.

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefit summary is available on the plan's or insurer's site.

Plan Name	Plan Contact Phone Number
Aetna Health of California Inc.	888-702-3862

Coverage summary	
Eligibility requirements	An employee or member whose coverage under a group contract has been terminated by an employer who is eligible for individual conversion coverage. Such coverage is not required to be offered under the following circumstances (*1)
The premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of the subscriber. See "Premium Rate" tab for this plan.
When and under what circumstances benefits cease	Benefits cease due to: • Fraud. • Loss of eligibility. • Failure to pay premiums or partial payment of premiums.
	• Member may terminate by written notice to plan. • Discontinuation of a product
	Benefits terminate for cause as follows: • Fraud - upon receipt of notice. • Loss of eligibility – the last day of the month in which you are no longer eligible. • Failure to pay premium -after 15 day notice. • Voluntary termination by member – the first of the month following adequate notice to the plan.

Coverage summary	
The terms under which coverage may be renewed	New sales are issued through the end of the calendar year. All accounts renew annually on January 1st.
Other coverage that may be available if benefits under the described benefit package cease	None
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care Plan Physician from a list of available Plan Physicians in the following specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. Members may change their primary care Plan Physician at any time.
Lifetime and annual maximums	$2,500 Annual Maximum Out of Pocket Limit per member per contract year
	$5,000 Annual Maximum Out of Pocket Limit per family per contract year. No lifetime maximum benefit.
Deductibles	None

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.		
	Doctor Office Visits	$25.00	
	Physical Exams	$25.00	
	Pediatric Visits	$25.00	
	Gynecological Visits	$25.00	
	Vision Exams	$25.00	
	Hearing Exams	$25.00	
	Scheduled Well Baby Visits (0-23 months)	$00.00	
	Scheduled Prenatal Visit and first Post-Partum visit	$00.00	
	Immunizations	$00.00	
	Family Planning	$25.00	
	Allergy Testing Visits	$25.00	
	Allergy injection Visits	$5.00	

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Outpatient Services	Outpatient Services, including but not limited to surgery and treatment, and diagnostic procedures		
	Outpatient Surgery	$100 per procedure	
	Voluntary Sterilization	$100 per procedure	
	Voluntary termination of pregnancy	$25 per procedure	
	Occupational Therapy	$25 per visit	
	Speech Therapy	$25 per visit	
	Physical Therapy	$25 per visit	
	Lab	$10 per encounter	Certain lab tests are covered at no charge. See the Evidence of Coverage for additional information about covered lab.
	Imaging (mammographies included except MRI, CT, and PET)	$10 per encounter	
	Imaging MRI, CT and PET	$50 per encounter	
	Other Tests and Procedures	$10 per encounter	
	Dermatology (UV light Treatment)	$0.00	
	Health Education Classes – Individual	$25 per visit	
	Health Education Classes – Group	$0.00	
	Allergy Testing	$25 per visit	
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room and board and supplies		
	Inpatient Maternity	$200 per day	
	Inpatient – Hospital (conditions other than maternity)	$200 per day	
	Inpatient - Multi-disciplinary Rehabilitation Services (These are intense coordinated rehabilitation services in more than one therapy, including,	$200 per day	

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
	but not limited to therapy services provided following a stroke or spinal cord injury.)		

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services.	$100.00 waived if admitted. (If admitted, hospitalization copayments apply	
Ambulance Services	Emergency ambulance transport	$100 per trip	
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician <u>Participating Retail Pharmacy:</u> 30-day Supply (Generic/Brand) Generic Formulary Prescription Drugs Brand Name Formulary Prescription Drugs <u>Participating Mail Order Pharmacy:</u> 100-day supply Generic formulary Prescription Drugs Brand Name Formulary Prescription Drugs Sexual Dysfunction Drugs	 $10 $35 $20 $70 50% of charges	

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Durable Medical Equipment	Home medical equipment, including, but not limited to, a oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies. Includes Durable Medical Equipment, Supplies, Prosthetic Devices, and Braces. Other items listed above may be covered under other benefit categories. Items used during covered Hospital stay or Skilled Nursing Facility. Items used at home	$00.00 Not covered except for a small number of items that are covered at 20% of charges	Durable Medical Equipment is covered in accord with our DME formulary guidelines. See the evidence of Coverage for additional information about covered DME
Mental Health Services	Inpatient and outpatient mental health services, including mental disorders and severe emotional disturbances for children. Outpatient Outpatient Mental Health Parity Inpatient Inpatient Mental Health Parity	$12 per visit for group sessions. $25 per visit for individual sessions $25 per visit $200 per day $200 per day	20 individual or group visits per calendar year No Visit Limitations 30 day limitation per calendar year No Day Limitations
Residential Treatment	Transitional residential recovery services.	$100 per admission	Up to 60 days per calendar year not to exceed 120 days in a consecutive 5-year period.

Benefits Summary (**2) & (***3)		**Co-payments**	**Limitation**
Chemical Dependency Services	Substance abuse treatment or rehabilitation In the Hospital - detoxification Outpatient Detoxification Outpatient Individual Outpatient Group Transitional Residential Recovery Services	 $200 per day $25 per visit $25 per visit $5 per visit $100 per admission	 Up to 60 days per calendar year, not to exceed 120 days in a consecutive 5 year period
Home Health Services	Home health and Hospice care services (****4) Hospice care Home health care	 $0.00 $0.00	 Part-time or Intermittent home health covered up to: Up to 2 hours per Visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist **and** up to 4 hours per visit for visits by a home health aide. Up to 3 visits per day. Up to 100 visits Per calendar year.
Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facility service Custodial Care	$0.00 Not covered	100 days per benefit period

(*1)

(a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;

(b) coverage was terminated because the employee or member failed to pay amounts due the plan;

(c) the employee or member was terminated for cause as set forth in the Evidence of Coverage;

(d) the employee or member intentionally furnished incorrect information or otherwise improperly obtained benefits of the plan;
(e) the employer's insurance coverage is self-insured;
(f) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group whether insured or self-insured;
(g) the employee or member is covered for similar benefits under an individual contract or policy; and
(h) the person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(2)** This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in the benefit summary.

(*3)** Percentage copayments represent a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less, and enrollees are also responsible for any excess amount.

(******4**) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.

(*******5**) Once enrolled in the Conversion plan, an enrollee who subsequently becomes eligibile for Medicare does not lose his/her eligibility to remain enrolled in the Conversion plan.